

FAMILY OPTOMETRIC CARE
J. Brent Meek, O.D. ▪ Lisa A. Kopper, O.D.

How were you made aware of our office? _____ Today's Date _____

Patient's Full Name _____

Gender: Male / Female Marital Status: Single _____ Married _____ Divorced _____ Other _____

Mailing Address _____ City _____

State _____ Zip _____ Home Phone _____ Alt Phone _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ SSN _____

E-Mail Address _____

I would like my appointment reminders by: _____ Mail _____ Email

Insurance for Eye Care _____ Insured Party's Name _____

Date of Birth _____ SSN or PIN _____ Employer _____

Relationship to Patient _____ Phone _____

FEE POLICIES

The patient, not the insurance company, is responsible for his/her bill.

If current insurance information is provided, we will bill insurance for any covered services and materials. Copays, deductibles or charges not covered by your insurance are to be paid in full at the time of service. If you have any questions regarding fees or any of the information explained above, please discuss it with the receptionist **before** you see the doctor.

I have read and understand the fee policies and agree to pay for services rendered.

Signature (Patient, Parent or Guardian)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

The undersigned Patient or legally authorized representative of the Patient acknowledges that he or she personally received a copy of Family Optometric Care's Notice of Privacy Policies.

Signature: _____ Date: _____

Patient: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies. Acknowledgement could not be obtained because:

_____ Individual refused to sign _____ Communication barriers _____ Other (Specify:) _____